STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. M-04/09-196
	)	
Appeal of	)	

INTRODUCTION

The petitioners, the parents of children who live together, appeal the decision by the Department for Children and Families, Economic Services Division, Health Access Eligibility Unit (HEAU) terminating their eligibility for VHAP and requiring the father (hereinafter referred to as the petitioner) to obtain employer-sponsored insurance (Catamount-ESI), even though the benefits under that program are markedly less generous than VHAP due to the particular chronic medical condition from which he suffers.[1]

The following facts are based on the undisputed representations of the parties at a hearing held in Barre on May 14, 2009, several written responses to inquiries by the hearing officer filed by the Department through August 21, 2009, and on the Department's representations to the Board at its meeting on September 1, 2009.

FINDINGS OF FACT

[1] The mother, who does not have access to insurance through her employer, was found eligible for CHAP.

1. The petitioner, who was receiving VHAP, reapplied for health benefits in March 2009. In a decision dated March 16, 2009 the Department found the petitioner eligible for premium assistance under his employer-sponsored insurance (Catamount-ESIA).

2. The petitioner does not dispute that his household now has countable monthly employment income of $4,066, which places them over the applicable VHAP maximum of $2,836.

3. Unfortunately, the petitioner suffers from Crohn's disease, a chronic intestinal condition, which requires a regimen of expensive pharmaceutical treatment and frequent doctor visits. Above and beyond the monthly premium (only partially subsidized by the Department), the employer's health plan includes a $300 per year deductible before any treatment is covered. Beyond that, it covers only 80 percent of the petitioner's medical costs up to a yearly out-of-pocket (i.e. "cost-sharing") maximum of $3,000, which the petitioner credibly asserts he will certainly incur every year due to the extensive treatment necessary for the control and management of his disease.

4. The CHAP plan, if the Department were to determine that it was more "cost effective" (see *infra*), would include a deductible of $250 and limit all other out-of-pocket (cost-

sharing) payments to $800 a year. The petitioner did not have to pay any of these costs when he was on VHAP.

5. If the petitioner were eligible for "chronic care management services", neither Catamount-ESI nor CHAP would require that the petitioner make *any* out-of-pocket (cost sharing) payments for care or services related to the treatment and management of his Crohn's disease that would be covered under VHAP.

6. The Department's position is that Crohn's disease is not a chronic condition that it has "selected" for inclusion in chronic care management (or "wraparound") services, and that the petitioner cannot obtain coverage for any of the cost sharing expenses he incurs to treat and manage his Crohn's disease.

ORDER

The Department's decision is modified. If the petitioner remains enrolled in Catamount-ESI, or if the Department chooses to enroll him in CHAP, the Department shall pay all of the petitioner's cost sharing expenses related to the treatment and management of his Crohn's disease.

REASONS

As a general matter, an income-eligible adult can be enrolled in CHAP if he "does not have access to an approved, cost-effective, ESI plan". W.A.M. §§ 5900 and 5913. In this case, the Department has determined that the petitioner must enroll in his employer's insurance plan, with premium assistance, rather than be enrolled in CHAP.[2]

The Department's employer-sponsored insurance (ESI) premium assistance program was created and is governed by statute. 33 V.S.A. § 1974(c) provides, in pertinent part:

> (4) In consultation with the department of banking, insurance, securities, and health care administration, the agency shall develop criteria for approving employer-sponsored health insurance plans to ensure the plans provide comprehensive and affordable health insurance when combined with the assistance under this section. At minimum, an approved employer-sponsored insurance plan shall include:
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> (A) covered benefits to be substantially similar, as determined by the agency, to the benefits covered under Catamount Health; and
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> (B)(i) until January 1, 2009 or when statewide participation in the Vermont blueprint for health is achieved, appropriate coverage of chronic conditions in a manner consistent with statewide participation by health insures in the Vermont blueprint for health, and in accordance with the standards established in section 702 of Title 18.

[2] Although, the Department could switch the petitioner to CHAP if it determines that the petitioner's Catamount-ESI plan is no longer "cost effective". See W.A.M. § 5924.4.

Section 7(a) of the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), Rules for Catamount Health Insurance provides:

> Catamount Health carriers shall provide insureds access to chronic care management programs. Such programs shall be subject to approval by the Commissioner. Chronic care management programs shall be consistent with the purposes of the Act, including the use of criteria substantially similar to the chronic care management program established under 18 V.S.A. § 702 and 33 V.S.A. § 1903a, as amended.

W.A.M. § 5924.2 of the Department's (DCF's) Premium-Assistance Program Rules provides, in pertinent part:

> (a) VHAP-ESIA or Catamount-ESIA will only be extended to subsidize the cost of plans that OVHA approves as comprehensive and affordable.
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> (b) An ESI plan will be approved if it conforms to the following standards:
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> . . .
>
> (2) Once statewide participation in the Vermont blueprint for health is achieved, the plan includes appropriate coverage of chronic conditions as specified in the blueprint and in accordance with the standards established in section 702 of Title 18.
>
> (3) The plan's in-network deductible for health-care services is not in excess of: $500 for an individual and $1,000 for two people or a family.

Examples of "chronic conditions" and "chronic care" are listed in 18 V.S.A § 702(f)(1) and in § 3(d) of the BISHCA Rules. Although neither specifically lists Crohn's Disease, both sections provide that chronic conditions shall "include,

but are not limited to" those specifically listed. The same language of inclusion appears in 33 V.S.A. § 1974(c)(1)(A), the statute that governs the Department's premium assistance plans for employer sponsored insurance (see *supra*), and in the Department's own regulation, W.A.M § 5901C. Moreover, the statute creating the "chronic care management program" directs that the administration "shall include a broad range of chronic conditions in the chronic care management program". 33 V.S.A. § 1903a(b).

The major benefit of chronic care management, or "wraparound", services is that they cover all "cost sharing" expenses of chronically ill individuals that are incurred under Catamount plans (Catamount-ESI and CHAP) that would be covered under VHAP. W.A.M. §§ 5952A & 5962A. In the petitioner's case, wraparound services would likely reduce his annual cost sharing expenses by $3,000 under his present Catamount-ESI plan, and by $800 if he were enrolled in CHAP.

In its written and oral representations submitted in this hearing the Department concedes that it has no published or legally promulgated regulations or policies to determine which "chronic conditions" are included in its "chronic care management" programs, and which are not. It also concedes that nothing in any of the governing statutes or regulations

dictates the exclusion of Crohn's Disease or any other chronic condition. Nonetheless, the Department maintains that it has authority to "select" (and, by extension, to exclude) certain chronic conditions for coverage "based upon their contribution to total past Medicaid costs, predicted contribution to future costs, legislation defining chronic conditions, and conditions judged most likely to be impacted by the types of services OVHA is able to provide." Although there may well be some arguable *administrative* or *fiscal* justification for this position, it is clearly unlawful.

First, it assumes a degree of discretion that is simply absent from a plain reading of any of the above statutes or regulations. Nothing in the language of any of the statutes or regulations cited by the Department can be read as conferring authority for the Department to provide coverage for certain "chronic conditions" and to withhold it from others, for *any* reason. As noted above, the language in *all* the above-cited provisions is clear that the benefits of "chronic care management" are intended to be inclusive and liberally applied. *This includes 18 V.S.A. § 702, which is specifically referenced in the Department's own regulation setting forth the scope of "chronic-care wraparound coverage" at W.A.M. § 5962C.*

Second, The Department's "selection" policy of chronic care management, even if arguably not expressly prohibited by statute, is plainly contrary to the statutory *purposes* of the program. 33 V.S.A. § 1981 sets forth the programs "policy and purpose" as follows:

> The Catamount Health assistance program is established to provide uninsured Vermont residents financial assistance in purchasing Catamount Health, a defined package of primary, preventive, hospital, acute episodic care, and chronic care, *including assistance in preventing and managing chronic conditions*.

(Emphasis added.) Nothing in the above language states or implies that the benefits of the program are, or can be, limited only to certain chronic conditions the Department chooses to "select". Furthermore, 18 V.S.A. § 702 (the statutory provision specifically cited in the Department's regulations, see *supra*) includes the provision that it is the intent of the legislature that there be "full participation" by health providers in all aspects of the "Blueprint for Care" (which includes the Department's chronic care management program) by January 1, 2009. The Department's continuing policy of withholding chronic care management services from individuals unfortunate enough to suffer from a "wrong" (i.e. non-"select") chronic condition, like Crohn's

disease, simply cannot be reconciled with the above purposes and directives.

Third, even if it could be concluded that the above statutes somehow allow or condone the authority to "select" a limited range of chronic conditions for coverage, and to exclude others, there is no language in any of the statutes that can remotely be read as exempting the Department from the basic requirements of due process under the Vermont Administrative Procedures Act (APA). See 3 V.S.A. §§ 801 *et seq.* As noted above, the Department maintains that it has never specifically considered and rejected Crohn's disease for coverage, and it admits that it has adopted no regulations or procedures setting out this exclusion. However, inasmuch as the Department admittedly has chosen to "select" a limited number of types of chronic conditions that it *does* cover, there is no question that due process requires specific rulemaking in this regard. See *In re Diel,* 158 Vt. 549 (1992). Indeed, nothing in the statutes cited by the Department or in the Administrative Procedures Act exempts it from rulemaking regarding *any* aspect of eligibility or coverage under *any* of its medical programs. See 3 V.S.A. §§ 831 *et seq.* In the admitted absence of any regulation or validly promulgated policy regarding which chronic conditions

are, and are not, eligible for enhanced (i.e. "wraparound") coverage, the Department's *de facto* exclusion of *any* chronic condition, based solely on the disease itself, must be considered arbitrary and a violation of procedural due process under the APA.

Fourth, especially given all the above-cited legislative provisions, the Department's conscious and deliberate *de facto* creation of disadvantaged classes of individuals who suffer from particular chronic diseases, requiring them to pay more for their health care than individuals with other "select" chronic conditions, patently violates fundamental notions of equal protection and "common benefits" guaranteed under the U.S. and Vermont constitutions.

Finally, even if it could be concluded that the Department's exclusion of Crohn's disease from its chronic care management program *is* lawful (i.e., the entire analysis above notwithstanding), at a minimum, the petitioner in this case should have been allowed to enroll in CHAP, which would have at least limited his annual out-of-pocket expenses to $1,050 (see *supra*), instead of the $3,300 he is now incurring. The fact that the petitioner's current ESI plan costs him $2,250 more per year than CHAP clearly renders his employer's insurance plan not "affordable" within any plain

or common-sense reading of 33 V.S.A. § 1974(c) or W.A.M. § 5924.2 (*supra*). Furthermore, 33 V.S.A. § 1974(c) requires that "approved" ESI plans include "covered benefits to be substantially similar, as determined by the agency, to the benefits covered under Catamount Health". Whatever discretion it may have under this provision, it is plainly an abuse of that discretion for the Department to approve any ESI plan as "affordable" or "available" for any non-"selected" chronically ill individual, like the petitioner, who is forced to pay more than *triple* the amount every year for that ESI plan than he would pay for CHAP.

For all the above reasons, unless and until the Department includes Crohn's Disease in its chronic care management program, the Department must cover any and all cost-sharing expenses the petitioner incurs under Catamount-ESI (or CHAP) related to the treatment and management of his Crohn's disease. The Department's decision in this case is modified accordingly.

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